199 500). Consumption fell from 9·81 litres of pure alcohol per adult to 9·47 litres.[3]

The categorical statement that "as affordability increases so does consumption and vice versa" is simply not true. The figure opposite this statement shows that during 1985-9 affordability increased sharply while consumption levelled off and then fell.

Anderson is rather scornful of current education campaigns that focus on sensible drinking because they may be counterproductive to his favoured population approach, which seems to entail elements of compulsion. In the *Health of the Nation* the government accepts that, in the end, people cannot be coerced into good health and that imposed strategies are valueless. The key seems to be education and not coercion that is based on flawed statistics and statistical reasoning.

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AUTHOR'S REPLY,—Communities with increasing aggregate levels of alcohol consumption tend to support increasing numbers of heavy drinkers and so increasing numbers of people with alcohol problems. This is a consistent finding across countries and over time and has been well reviewed and reported nationally and internationally.[1-3]

A persistent finding over time and across countries is that the most important determinant of alcohol consumption is affordability.[1,2,4] The relative stability of alcohol consumption in a period of increased affordability over the past five years in the United Kingdom does not refute this but argues for the effectiveness of health education programmes.

The relation between availability of alcohol and its consumption has been reviewed and confirmed by work by the Addiction Research Centre in York funded by the Economic and Social Research Council.[4]

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Zidovudine after occupational exposure to HIV

SIR,—I read D J Jeffries's editorial,[1] on prophylaxis with zidovudine after occupational exposure to HIV, and the following correspondence[2,3] with mixed feelings. Colleagues in Western countries are occasionally exposed to a patient in a so called high risk group. In our part of the world, however, we are all at high risk, doctors and patients alike.

I estimate—on good grounds—that 30% of my patients are HIV positive. I do over 100 operations a month, and from my personal experience I agree with A G Bird and colleagues that percutaneous injuries occur in about 15% of operations not counting occasions when patients' blood comes into contact with skin or splashes the eye without injury and disregarding the fact that we often operate while wearing used, resterilised gloves. On the basis of these figures I injure myself on average 4·5 times each month while operating on patients infected with HIV and would therefore be taking zidovudine continuously for the rest of my working life, if I followed Jeffries's recommendations. This would apply to all doctors, midwives, and surgeons in our part of Africa.

Zidovudine is not available in Kampala, but, even if it was, the side effects, dangers, and high cost of its long term use make the discussion about giving it after occupational exposure quite irrelevant and unrealistic in our situation.

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Coronary heart disease and elderly people

SIR,—Robert Beaglehole comments on the lack of evidence justifying the treatment of risk factors for cardiovascular disease in elderly people.[1] We have recently noted both an increasing number of inquiries from general practitioners about the justification for treating hyperlipidaemia in elderly people and an increased number of referrals of elderly patients with hyperlipidaemia to our lipid clinic.

The referral of two fit, slim, normotensive, and non-smoking women in their 70s with no family history of ischaemic heart disease prompted an inquiry into recent requests for estimations of cholesterol concentration made to our biochemistry department by general practitioners (table). This indicated that between the first six months of 1989 and 1991 requests had risen fourfold in patients aged under 65 and sixfold in patients aged 65 and over. The requests comprised 14·4% of all requests by general practitioners in the first half of 1991. Requests by hospitals remained static over this period. Requests from general practitioners arise mainly from the well person or lifestyle clinics that have flourished since the new general practitioner contract was introduced in 1990.

As Beaglehole comments, no clinical trials have assessed the efficacy of lipid lowering regimens in reducing cardiovascular morbidity or mortality in elderly people, and extrapolations from trials conducted in middle aged men may be unjustified.[2] Vigorous treatment of hyperlipidaemia is certainly indicated in younger subjects at high risk, but lack of evidence that treatment reduces total mortality and some concern that non-cardiovascular mortality may be increased[3] reinforce the case for a conservative approach to lipid lowering regimens in patients aged over 65.

Number of requests for serum cholesterol estimations to biochemistry department of Stobhill General Hospital, 1989-91

Age (years)	1989 Months 1-6	1989 Months 7-12	1990 Months 1-6	1990 Months 7-12	1991 Months 1-6
Requests from general practitioners					
16-	1307	1761	3046	4318	5231
65-	125	173	377	582	724
≥75	10	23	72	120	160
Requests from hospitals					
16-	2031	1922	2007	1977	2238
65-	281	293	318	266	361
≥75	64	76	44	65	59

Current guidelines do not state that systematic screening for hyperlipidaemia should *not* be carried out in elderly people,[4,5] perhaps on the grounds that a lipid lowering diet may do some good and cannot do harm. This ignores the anxiety and strain on limited budgets that may follow advice to modify lifelong dietary patterns. Several elderly patients with hyperlipidaemia referred to our lipid clinic have been upset by prior advice to follow a lipid lowering diet. They were delighted to be told to ignore their serum cholesterol concentration and resume their previous dietary pattern, which arrival at pensionable age might indicate had served them well.

Perhaps a citizen's charter for elderly people should guarantee that arrival at pensionable age (and certainly at age 70) provides immunity from lipid screening and lipid lowering diets and drugs. Immunity should remain in force until new evidence indicates that the introduction of lipid lowering regimens produces tangible benefits in old age.

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Use of thalidomide in leprosy

SIR,—The use of thalidomide in the treatment of erythema nodosum leprosum has been discussed.[1-3] There is no doubt that such treatment is effective; but there is also no doubt that the side effects of thalidomide, particularly induced polyneuritis and teratogenicity (allergic vasculitis, thrombocytopenic purpura, and myxoedema have also been reported, and in animals toxicity depends on both the species and the sex[4]), are also of great concern to clinicians and others working with people with leprosy, particularly in developing countries. The lack of control over such a potentially dangerous drug both in clinics and when it is released to patients and the possible misuse of the drug for its known sedative properties are among the reasons for such concern.

The risk-benefit analysis of M F R Waters[5] would provide sufficient justification for using thalidomide if that was the only option for treatment. Though this may be the case now, important advances have been made in developing more suitable alternative compounds. The work of O'Sullivan is particularly important and is well known to those concerned in the chemotherapy of leprosy. He has prepared analogues of clofazimine that do not cause extensive pigmentation, have much improved pharmacokinetic properties, are active against drug resistant organisms, and retain, in some cases, anti-inflammatory properties.[5-7] The development of these compounds should be a priority of the world community, but sadly this is not the case because leprosy is regarded as an orphan disease.

Clofazimine and its analogues, however, have potential in the treatment of other diseases that